**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor Name and Address:<br>NORTHWEST TEXAS HEALTHCARE<br>3255 WEST PIONEER PARKWAY<br>ARLINGTON, TX 76015 | MFDR Tracking #: M4-05-A525-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Carrier's Austin Representative Box #:<br>TEXAS MUTUAL INSURANCE CO<br>BOX # 54 | Date of Injury:<br>Employer Name:<br>Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This is considered a 'trauma' admit and can be exempt from the perdiem rates. Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. Medicare would have allowed this facility $11550.68 for DRG 440. We are asking the allowable to be 140%-over-Medicare. This would leave a supplement payment of $12468.95 due at this time."

**Amount in Dispute:** $12,468.95

## PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "It is this carrier's position that a fair and reasonable reimbursement for the dates of service in dispute was reimbursed. This carrier reimbursed the requester this carrier's fair and reasonable per diem reimbursement for a trauma in-patient surgical stay at $1,234 a day for 3 days. In fact, this carrier inadvertently reimbursed the requester above this carrier's fair and reasonable reimbursement." "Texas Workers' Compensation Commission contracted with Ingenix to develop hospital inpatient payment fee guideline. The Texas Workers' Compensation Commission Ingenix Summary 2002 (Exhibit 2) recommends (low end range) 107% to (high end range) 121% payment adjustment factor of Medicare inpatient hospital fee guideline to meet the statutory requirements found in Section 413.011 of the Texas Workers' Compensation Act of the Texas Labor Code." "The requester identified $11550.68 as the Medicare allowable to this facility for DRG 440. It is this carrier's position that based on TWCC's own study 121% is reasonable. The requester is requesting 140%."

**Response Submitted by:** Deborah Bailey, Texas Mutual Insurance Co., 221 West 6th Street, Ste. 300, Austin, TX 78749

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 12/4/2004 through 12/7/2004 | 480, 730, 793, CAC-W1, CAC-24, CAC-97, 198, 878, 18, CAC-W4, 891 | Inpatient Surgery Admission | $12,468.95 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on July 20, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 27, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code(s):
   - 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
   - 730-Denied as included in per diem rate.
   - 793-Reduction due to PPO contract.
   - CAC- W1-Workers Compensation state fee schedule adjustment.
   - CAC-24-Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 198-Allowance was reduced as per contractual agreement.
   - 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.
   - 18-duplicate claim/service.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 891-The insurance company is reducing or denying payment after reconsidering a bill.

2. The Respondent raised the issue of a PPO contract; however, a review of the submitted EOBs does not support a PPO reduction was taken. The respondent did not submit a copy of a contractual agreement to support this EOB denial. The respondent states in the position summary that "This carrier reimbursed the requester this carrier's fair and reasonable per diem reimbursement for a trauma in-patient surgical stay at $1,234 a day for 3 days"; therefore, a contractual agreement issue does not exist and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.

3. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.

4. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 927.20. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

5. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

7. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The requestor did not submit a copy of the operative report, anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).

8. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).

9. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states that "We are asking the allowable to be 140%-over-Medicare. This would

leave a supplement payment of $12468.95 due at this time."

- The requestor does not discuss or explain how additional payment of $12,468.95 would result in a fair and reasonable reimbursement.
- The requestor did not discuss or explain how it determined that the 140% Medicare rate would yield a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(B), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

**DECISION:**

| | | **8/30/2011** |
|---|---|---|
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**